

Consumer's Guide to Health Plans in Rhode Island 2001

*A Publication of
the Rhode Island Department of Health
in Cooperation with
the Health Plans of Rhode Island*

Safe and Healthy Lives in Safe and Healthy Communities

Consumer's Guide to Health Plans 2001

The Rhode Island Department of Health (HEALTH) developed this Consumer's Guide with the Health Plans to help you be an active and informed consumer. Health Plans must provide its subscribers with the Consumer's Guide. It contains general information about Health Plans and how they operate. Benefits and policies of a specific Health Plan are summarized in the Consumer Disclosure, provided by the Health Plans to eligible subscribers. Official Plan Documents, also provided by each Health Plan, contain complete information on benefits and policies of individual Health Plans. The Consumer's Guide and Health Plan Disclosures are available on the HEALTH website, www.healthri.org. Print copies are available through the office of the Director of Health, at 401 222-2231.

The WebSite for the Rhode Island Department of Health contains information about Public Health and the Health Care Community. By logging on to www.healthri.org, you can access the following information, plus much more:

Public Health News:

- Updates on Disease Outbreaks, such as West Nile Virus
- Information about Infectious/Chronic Diseases
- Media notices, advisories and health alerts

Health Care Quality:

- Physician Profiles – Information on licensing or complaints about Physicians
- Nursing Home Survey Reports
- Licensing 2000 – Information regarding any person licensed through the Office of Professional Regulation
- Information from the facility survey conducted jointly by the Department of Health and the Joint Commission on Hospital Accreditation

Environmental Health:

- Information about Drinking Water
- Fish Advisory

Regulations:

- Notices of Public Hearings
- Regulations for all health professionals, facilities and services

E-Mail!

Contact us with your questions or concerns. One of our staff members will respond to you ASAP.

Contents

Why Are You Getting This Information?.....	3
Not All Health Plans Are The Same.....	3
General Information About Health Plans.....	3
How Do You Know If A Covered Service Will Be Paid?.....	6
Call The Health Plan If You Have Questions.....	7
Health Benefits Required Under Rhode Island Law.....	7
Standardized Definitions	10

The Standardized Definitions give explanations and examples to help you understand words used in this Guide.

Why Are You Getting This Information?

Health care has changed a lot in recent years. More and more people are covered by Health Plans in which consumers, health care providers and the Health Plan must work together as partners, to get the best results.

The Health Care Accessibility and Quality Assurance Act (1996)

Under this law, Health Plans must be certified by the Rhode Island Department of Health and disclose certain information to inform and protect consumers. For more information contact the Division of Health Services Regulation at 401 222-6015.

All Health Plans are required to:

- meet minimum standards for certification
- give consumers information that makes it easier to understand and compare benefits
- use standardized definitions when disclosing information
- report information on access and quality
- keep personal health information confidential.

Not All Health Plans Are The Same

Health Plans differ in the way they handle health care services, such as:

- what health services are included in the Health Plan (covered services)
- which doctors you may go to for health care services (participating provider network)
- who decides what health care services are needed (medical necessity and utilization review)
- how the Health Plan pays providers for health care services (financial arrangements)
- how much you have to pay for health care services (out-of-pocket expenses).

All Health Plans must report certain statistical performance information to the Director of Health. This information helps you to stay well-informed. Information regarding Health Plan performance is available:

- on the HEALTH website, www.healthri.org.
- in single print copies by contacting your Health Plan.

So, it is important to know as much as you can about your Health Plan.

General Information About Health Plans

Key questions for most current and future enrollees of Health Plans include:

(Continued on next page)

Q Is my provider in the plan?

A A participating provider has an agreement with a plan to deliver health care services. Participating providers include doctors, hospitals, drug stores, laboratories, and other persons or organizations who deliver health services.

- You may have to use participating providers.
- You may have to choose a primary care provider.
- You can find out if your doctor, drug store, mental health therapist, nursing home or other provider participates (is in the provider network).
- You can get a written list (updated annually) of participating providers from the Health Plan.

If you don't use a participating provider, the Health Plan may not pay for the services you get. You may have to pay. You should check on this in advance.

Q What services are covered?

A Specific health care services that your Health Plan agrees to provide or pay for are known as covered services.

- Check the *Consumer Disclosure* for a summary. Disclosures are available on the Health Plan website, or by contacting your Health Plan.
- Request the Official Plan Documents for complete information about a particular Health Plan.
- Check the Health Benefits Required by Rhode Island law. (Page 8)

Just because a service is covered doesn't mean that a Health Plan will always pay for it. Other rules, like medical necessity, may apply.

Q Are there limits on covered services?

A Health Plans may limit payment for some services by:

- the number of services (example: 20 outpatient physical therapy visits)
- the dollar amount of payments (example: \$900 for dental services)
- the time period (annual limits or lifetime limits)
- finding that the services are not medically necessary
- excluding some services under specific circumstances (such as surgery for cosmetic purposes).

Limits may apply per person or for the entire family. When the limit is reached, you may have to pay for additional services. For a description of the limits and restrictions for a specific plan, ask for the *Consumer Disclosure* or refer to the Official Plan Documents.

Q Are experimental treatments covered?

A Some health care treatments are considered experimental and may not be covered.

- To find out if a treatment recommended by a provider is experimental and if it will be paid for, call the Health Plan directly.

Q How are urgent care services handled?

A An urgent condition is a serious but not life-threatening health problem which needs to be treated by a provider within 24 hours to prevent it from getting worse. Make sure you know what the Health Plan wants you to do when you have an urgent health care problem. Do you need prior approval?

Q How are emergencies handled?

A An emergency is a health problem that needs to be seen by a provider right away to prevent permanent damage or death. Make sure you know what the Health Plan wants you to do if you think you are having an emergency. Health Plans have to tell you whether or not they will pay for:

- examinations to determine if an emergency exists
- emergency treatment services
- follow-up services to emergencies.

Q What expenses do I have to pay? (out-of-pocket expenses)

A Health Plans cover most, but generally not all of the costs of covered services. You may have to pay for:

- co-insurance, co-payments, annual and service deductibles
- the full-cost of
 - non-covered services
 - services from non-participating providers
 - services delivered by a participating provider without a referral or prior authorization, if one was required
 - covered services not considered to be medically necessary.
(see sections on Utilization Review and Appeal Process)

Q How does the Health Plan pay providers?

A A Health Plan must tell you about the kind of financial arrangements it has with providers, and if those arrangements involve capitation or financial risk-sharing (See definitions).

Q

How is the Health Plan coverage renewed or canceled?

A

A Health Plan must tell you when and how your coverage may be renewed or cancelled, including whether it has the right to increase premiums.

How Do You Know If A Covered Service Will Be Paid For By The Health Plan?

Utilization Review

Most Health Plans will only pay for covered services if they are medically necessary. If the Health Plan decides that a covered service is not medically necessary, the Health Plan will not cover or pay for the service.

The process used to determine if services are medically necessary is called utilization review. Utilization review may be done:

- before a service is delivered (prior authorization)
- during service delivery (concurrent review)
- after a service is delivered (retrospective review).

A Health Plan may contract with another company to do utilization review. When this happens, the other company is bound by the same laws governing Health Plans.

When a Health Plan decides, through utilization review, that a service is not medically necessary, it will not pay for a covered service. Depending on the situation:

- the provider may bill you directly for the service.
- you may have to pay the provider.
- the provider may be responsible for the cost of the service.

Prior Authorization

It is important for you to know if a covered service needs advance review and approval (prior authorization) and whether the Health Plan will pay for the service. To find this out:

- refer to the *Consumer Disclosure*.
- check your Official Health Plan Documents or member handbook.
- call the Health Plan Consumer/Customer Services office.
- discuss it with your provider.

Appeal Process

When a Health Plan determines a covered service is not medically necessary and denies

(Continued on next page)

payment for the service, you may appeal the decision according to state law. The Health Plan or its designated utilization review company must provide the following in writing to both the patient and provider:

- detailed reason for the denial that is case and/or criteria specific
- instructions about how to appeal including steps and any deadlines
- a statement that the appealing party may request a copy of the actual criteria used in the denial.

Either the patient or provider can appeal by calling or writing to the Health Plan or its designated utilization review company.

The Department of Health is responsible for investigating complaints about utilization review. Call the Division of Health Services Regulation, 3 Capitol Hill, Providence, Rhode Island 02908, telephone 401 222-6015.

Call The Health Plan If You Have Questions

The *Consumer Disclosure* and the Official Plan Documents may not answer all your questions. Sometimes, it is best to call the Health Plan when you don't understand something or if you have an important question. When you talk to the Health Plan representative, write down the following information:

- date and time of the call
- name of the person you talked to
- the topic or question you discussed
- what the Health Plan told you to do
- if you asked for written verification.

If you are still not clear or not satisfied with the response, put your request or complaint in writing and ask the Health Plan for more help or for written instructions.

Subscriber Input

Each Health Plan must give local individual subscribers and providers an opportunity to comment about its health care services and to suggest improvements. Consumers may contact the Health Plan for more information or a written description of the process.

Health Benefits Required Under Rhode Island Law

Health Maintenance Organizations (HMOs) and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. See the table on pages 8 and 9 for a summary of these requirements.

Health Benefits Required Under Rhode Island Law

HMOs and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. These laws do not apply to Medicare, Medicaid, ERISA self-funded plans or supplemental (e.g. Medigap) or single disease (e.g. Cancer coverage) health insurance policies (check with your workplace benefits administrator). These “mandated benefits” (see summary list below) often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full—other conditions and restrictions not mentioned here may apply. For more information about specific “mandated benefits,” contact your Health Plan representative or the Rhode Island Department of Business Regulation at 401 222-2223.

Type of Health Service	Explanation and Legal References
<u>MANDATED HEALTH BENEFITS</u>	
Acupuncture	Coverage provided as an optional rider to health care coverage. (RIGL 27-18-55)
Chronic Disabilities	No insurer shall discontinue reimbursement or benefits for chronic disabilities unless patient has exhausted benefits and required notice is sent; for group coverage only. (RIGL 27-18-32; 27-20-22; 27-41-37)
Diabetes Treatment	Diabetes equipment and supplies, self-management education from licensed and certified health care provider when medically appropriate and prescribed by a physician. Co-payment or deductible not greater than that imposed for other supplies and services. (RIGL 27-18-38; 27-41-44)
Drug Coverage Non-formulary Medications	Coverage for non-formulary medication when prescribed by a physician if believed medically necessary, and if it meets the medical exception criteria. (RIGL 27-18-50)
Contraceptive Medications	Coverage for approved contraceptive drugs/devices requiring a prescription. (RIGL 27-18--57)
Human Leukocyte Antigen Testing	Coverage for human leukocyte antigen testing for A, B, and DR antigens for utilization in bone marrow transplantation. (RIGL 27-18-49)
Infertility	Diagnosis and treatment of infertility, copayment (not to exceed 20%) limited to married individuals unable to conceive for one year. (RIGL 27-18-30; 27-20-20; 27-41-33)
Lead Poisoning	Diagnostic evaluation and screening for children under six years. (RIGL 23-24-6-9)
Cancer Screening	Mammogram and Pap smears in accordance with guidelines established by the American Cancer Society. (RIGL 27-20-17; 42-62-36; 27-41-30) Prostate and colorectal examinations and laboratory tests in accordance with ACS guidelines. (RIGL 27-19-48)
Mastectomy Treatment	Minimum 48-hour hospital stay after mastectomy; 24-hour stay after axillary node dissection. Prosthetic devices and/or reconstructive surgery to restore and achieve symmetry subject to deductible and coinsurance conditions applied to mastectomy. Time limit 18 months from original mastectomy. (RIGL 27-18-40; 27-18-39; 27-41-43)
Mental Health Parity	Medical treatment of serious mental illness covered same as other illnesses and diseases (duration, amounts, deductibles and co-insurance limits). (RIGL 27-38.2-1)
New Cancer Therapies	Coverage for cancer therapies (still under investigation) under certain circumstances - Phase II, III or IV clinical trials approved by National Institutes of Health and others. (RIGL 27-18-36; 27-20-27; 27-41-41)
Newborn Metabolic Screening, Hearing and Sickle Cell Disease Tests	Full benefit covered by all insurers including Medical Assistance; parents can object on religious grounds. (RIGL 23-13-13; 23-13-14; 23-13-15)
Hearing Aid Riders	Optional rider for hearing aids may be provided in insurance contracts. Hearing aid must be non-experimental, excludes batteries, cords, other assistive devices. (RIGL 27-18)

Type of Health Service	Explanation and Legal References
Off-label Cancer Drug Use	Insurers must cover drugs for cancer treatment if their use is recognized by standard medical references. (RIGL 27-55-2; 27-18-36.2)
Pediatric Preventive Care	Coverage for children including pediatric preventive care, copayments may apply. (RIGL 27-38.1-2)
Post Partum Hospital Stays	Maternity benefits including a 48 hour stay after vaginal birth and 96 hours stay after Cesarean section for mother and newly born child. Early discharge care to include home visits, parent education, assistance and training in feeding, and clinical tests. (RIGL 27-18-33.1; 27-41-30.1)
Primary Preventive Obstetric/Gynecological Care	Health Plans which cover obstetric and gynecological care shall permit annual visit in-network for routine gynecological care without requiring PCP referral (RIGL 27-18-44)
Substance Abuse	Medically necessary treatment for substance dependency (excluding tobacco and caffeine) up to 3 detoxification occurrences or 21 days and up to 30 days in intensive rehabilitation in any 12 months through appropriately licensed settings (inpatient, day/evening treatment, partial hospitalization); up to 30 outpatient hours (individual) and 20 hours (family members) in any 12 month period in licensed settings; lifetime benefit of 90 days rehabilitation. Non-RI facilities must meet reasonable criteria. (RIGL 27-38-1-9)

PROFESSIONAL SERVICE OPTIONS

Marriage/Family Therapists	Services of mental health counselors and marriage/family practice therapists, <u>excluding</u> marital and family therapy <u>unless</u> the individual is diagnosed with a mental disorder. (RIGL 27-18-35; 27-41-49)
Nurse Anesthetists	Coverage for services of a certified registered nurse anesthetist practicing under the supervision of licensed physicians or dentists.(RIGL 27-18-48)
Nurse First Assistants	Coverage for services of registered nurse first assistants (RIGL 27-18-48)
Nurse Midwives	Coverage for services of licensed midwives. (RIGL 27-18-31; 27-13-34)
Nurse Practitioners	Coverage for services of certified registered nurse practitioner and psychiatric and mental health nurse clinical specialists practicing in collaboration with or in the employ of a licensed physician. (RIGL 27-18-34; 27-41-39)

OTHER REQUIREMENTS

Childhood Vaccine	Requires Department of Health immunization program to include recommended childhood immunizations. (RIGL 23-144)
Discrimination Prohibited	Health care providers have a duty to provide services to any person in need of health services without regard to the person's race, sex, religion, age, or occupational status. (RIGL 42-62-11)
Genetic Testing	An insurer cannot use the results of genetic testing to reject, deny, limit, cancel or refuse to renew, increase the rates of or otherwise affect a health insurance policy contract. (RIGL 27-18-52)
HMO Alternative	Employers with 25 or more employees must offer option of licensed HMO and are not required to pay more for HMO than for basic benefit package. (RIGL 27-41-27)
MRI Quality Assurance Standards	Coverage for MRI (Magnetic Resonance Imaging) examination only if the provider meets state-approved quality assurance standards for taking, processing and interpreting MRI examinations. (RIGL 27-18-53)
Pre-existing Condition Clauses Prohibited	No limit on coverage for any pre-existing condition for any individual who has been continuously insured or covered for 12 months immediately prior to the date of application. (RIGL 27-18-37)
Right to Appeal Adverse Decisions	Subscribers have the right to appeal any decision by an insurer not to pay for a covered service due to medical necessity. (RIGL 23-17.12-9)
Whistleblower Protection	Protection under the law (RIGL 27-18-45) for physicians who report a violation, by the insurer, of a subscriber or Membership Agreement.

Standardized Definitions

To help ensure a patient's ability to make informed decisions regarding their health care, the director shall promulgate regulation(s) to provide for standardized definitions of the following, provided, however, that no definition shall be construed to require a health care entity to add any benefit, to increase the scope of any benefit, or to increase any benefit under contract. Enrollees should refer to their official plan document issued by their health plan for information regarding the specific terms and provisions of their health care coverage.

Adverse Decision: The cost of a covered service ordered by your provider is not paid by your health plan because the health plan decided that the service was not medically necessary. The health plan's decision not to pay for this health care service is called an adverse decision.

Example: Your doctor orders an x-ray, which is a covered service, but your health plan does not pay for the x-ray because it decided the x-ray was not medically necessary.

Allowable Charge: This is the most money your health plan pays your provider for a specific health care service.

Example: Your health plan pays a doctor no more than \$40 for an office visit.

Example: Your health plan pays a hospital no more than \$200 for an emergency room visit.

Annual Limits: Your health plan sets a maximum limit on the total number of health care services or on the total amount of money it pays for health care services each year. This limit is called an annual limit.

Example: Your health plan includes dental services. Each year your health plan pays up to \$900 in dental services. You pay for all dental services over the \$900 annual limit.

Example: Your health plan includes mental health counseling. The health plan pays for up to 20 visits each year. You pay for all outpatient mental health services after your 20th visit.

Appeal: When your health plan decides not to pay for a covered service, you may ask your health plan to review the decision. This review is called an appeal.

Example: Your health plan tells you it will not pay for your emergency room visit. You ask your health plan to look at the information again to see if they will change their decision and pay for the emergency room visit. You may want to give your health plan more information for this appeal.

Capitation: Capitation is one way that a health plan pays participating providers. It is a form of risk sharing. The health plan pays a participating provider a set amount of money per year for all of the covered services that he or she gives to an enrollee.

Example: Your health plan pays your doctor \$240 each year no matter how many times you visit the doctor.

Example: Your health plan pays the hospital \$480 each year for hospital care whether or not you go to the hospital for services.

Co-Insurance: Each time you receive certain health care services, you pay a percent of the allowable charge. Your payment is known as co-insurance.

Example: Your health plan will pay up to \$40 for an office visit. \$40 is the allowable charge. You pay 20% of the allowable charge or \$8, and your health plan pays the rest. The \$8 is your co-insurance.

Example: Your health plan's allowable charge for a day of hospital care is \$600. You pay 25% of the allowable charge or \$150, and your health plan pays the rest. The \$150 is your co-insurance.

Concurrent Review: You are currently being treated by your health care provider for a medical or health problem. A concurrent review occurs when your health plan reviews the covered services ordered by your provider while you are currently being treated for the medical or health problem. The health plan decides if the services are medically necessary as a part of its decision to continue to pay for services.

Example: You are in the hospital and your doctor wants to keep you in the hospital. Your health plan reviews your medical condition to decide if it will pay for more hospital days.

Example: Your provider is continuing your physical therapy treatment. Your health plan reviews your provider's orders to decide if it will pay for more physical therapy visits.

Co-payment: Each time you receive certain health care services, you pay a set amount of money. Your payment is known as a co-payment.

Example: You must pay \$10 to your doctor for each office visit and your health plan pays the rest. The \$10 is your co-payment.

Example: You must pay \$5 for each prescription and your health plan pays the rest. The \$5 is your co-payment.

Covered Services: Your health plan agrees to provide or pay for specific health care services as part of your health care coverage. These health care services are called covered services. (Also known as covered benefits)

Example: You are pregnant and your participating provider orders an ultrasound. Your health plan pays for the ultrasound because it is a covered service.

Example: You have a back problem and go to a massage therapist. Massage therapy is not a covered service. Your health plan does not pay for this service.

Credentialing: A health plan reviews the qualifications of a provider so he/she can be a participating provider in the health plan.

Example: Your health plan reviews the education, training, licensing and experience of a provider who wants to become a participating provider in the health plan.

Deductible: The amount of money that you must pay for covered services before your health plan begins to pay for the services.

Example: Your health plan includes a \$200 deductible. Each year, you must pay the first \$200 for health services before your health plan begins to pay for any services.

Example: Each time you are admitted to the hospital, you pay the first \$1,000.

Emergency Service: A service given to treat a person with a serious medical or health problem. That person needs to be seen by a provider right away to prevent permanent damage or death. A medical problem includes physical, mental, and dental conditions.

Example: Your child has a severe asthma attack and it is becoming more and more difficult for him/her to breathe.

Example: Your child threatens to kill him/herself and is extremely upset.

Example: Your child has taken drugs and has passed out.

Enrollee: An enrollee is anyone who is covered by your health plan. This may include you, your spouse, or your children.

Formulary: This is a list of medicines that your health plan pays for or provides when ordered by a provider in your health plan.

Example: Your doctor orders a medicine which is on the approved list of medications for your health plan. Your health plan pays for the medication except for any co-pay or co-insurance that you have to pay.

Example: Your provider orders a medicine which is **not** on the approved list of medications for your health plan. Your health plan does not pay for the medication. You must pay all of the cost for the medication.

Grace Period: Payment for your health plan coverage is due on a date set by the health plan. Your health plan coverage continues for a set number of days after this date — this is known as a grace period. If the bill is paid during the grace period, your health plan coverage continues. If the bill is not paid during the grace period, your coverage is canceled and you pay for all health care services received during the grace period.

Example: Payment for your health plan coverage is due on November 1, and payment is made on November 15, which is within the 30 day grace period. Your health plan coverage continues.

Example: Payment for your health plan coverage is due on November 1, and payment is not made during the grace period which ends on November 30. You no longer have health plan coverage and your health plan will not pay for any health care services you received after November 1.

Indemnity Insurance: This is one way that a health insurance company pays for health care. After you receive services you pay your provider in full. Then you ask your health plan to pay you back. Your health plan may refund some or all of the money you paid.

Example: You go to your doctor for an office visit and pay the bill. After the visit, you send the paid bill to your health plan and ask that your health plan pay you back. Your health plan may refund some or all of the money you paid.

Inpatient Services: Health care services which you receive when you stay one night or more in a hospital, nursing home, or rehabilitation center are called in-patient services.

Example: You have major surgery and you stay in the hospital for two days. This is two days of inpatient services.

Maximum Lifetime Benefit: The total amount of health care that your plan pays for a certain service while enrolled in that plan during your lifetime.

Example: Your health plan will pay for no more than a total of 100 outpatient physical therapy visits in your lifetime. After this maximum lifetime benefit has been reached, you pay the entire cost of all future outpatient physical therapy visits as long as you are a member of that plan.

Maximum Lifetime Cap: This is the total amount of money that your health plan pays for all of the care that you receive while in that health plan.

Example: Your health plan pays no more than one million dollars for your health care. After the maximum lifetime cap has been reached, you pay the entire cost of your future health care.

Medical Necessity: Your provider thinks you need certain health care services to treat your health care problem. Your health plan may review these services before, during or after you receive these services. Your health plan then decides if it thinks the services are needed based on its own medical or health care standards. If your health plan does not agree that you need the services, it will not pay for the service. Your provider and your health plan have made different “medical necessity” decisions.

Example: You fell and hurt your ankle. Your doctor orders an X-ray. Your health plan agrees that this is medically necessary and pays for the X-ray.

Example: You take your child to a hospital emergency room for a sore throat. Your health plan decides that it was not medically necessary to go to the hospital emergency room for treatment. Your health plan does not pay for the emergency room services.

Non-Covered Service: A health care service that is not provided or paid for by your health plan is known as a non-covered service. Your health plan does not pay for non-covered services. (Also known as excluded service)

Example: During an eye examination, your optometrist conducts a test on your eyes. This test is not a covered service of your plan. Your plan does not pay for this test. You must pay for the test yourself.

Official Plan Document: This is a formal booklet given to you by your health plan that describes your health care coverage in detail.

Example: Health plans may call this booklet your “subscriber certificate, member certificate, employee benefit manual, member handbook, employee handbook, evidence of coverage or certificate of coverage.”

Out-of-Network Provider: A provider who is not a participating provider in your health plan is known as an out-of-network provider.

Example: You go to a doctor for a flu shot and that physician is not a participating provider in your health plan. As a result, you may have to pay for all or most of the cost for these services.

Example: You go to a pharmacy to fill a prescription and that pharmacy is not a participating provider in your health plan. You may have to pay for all or most of the cost for this prescription.

Out-of-Pocket Expenses: Out-of-Pocket expenses are payments you make for health care services. This may include co-payments, co-insurance, deductibles, and payments for non-covered services.

Example: You have broken your leg and need crutches. The crutches are a covered service but require a \$25 co-payment. The \$25 co-payment is an out-of-pocket expense.

Out-Patient Services: Health care services provided at a hospital or other health care facility which do not require an overnight stay are known as out-patient services.

Example: You go to a hospital for minor surgery but you do not stay overnight.

Participating Provider: A provider is a person or an organization who can deliver health care services. A participating provider is a provider who has an agreement with your health plan to deliver health care services to people in that plan.

Example: You want to have a prescription filled at the pharmacy near your home. That pharmacy is a participating provider in your health plan. Your prescription can be filled at the pharmacy, and your health plan pays for all or part of the prescription.

Example: You need to have a blood test done. The laboratory that you go to is **not** a participating provider. Your health plan does not pay for the laboratory test.

Point-of-Service: Your health plan allows you to go to a provider who does not participate in your health plan. Usually, you pay more of the bill than if you went to a participating provider.

Example: You are treated by a doctor who is not in your health plan. You pay more for that service than if you were treated by a doctor who is a participating provider.

Pre-Existing Condition: A medical or health condition which was diagnosed or treated by a provider before you joined your current health plan.

Example: You had been treated for a heart condition before you enrolled in the health plan.

Premium: A premium is the amount of money paid for health plan coverage.

Example: The cost of your health plan coverage is \$200 a month. This \$200 which must be paid every month for your health plan coverage to continue is called your premium.

Prior-Authorization Review: A prior-authorization review occurs when your health plan requires that it review certain covered services before you receive them to decide if the services are medically necessary and if the health plan will pay for the services.

Example: You or your provider are required to call your health plan before you go to the emergency room. If you don't call the health plan first, your health plan may not pay for the emergency room visit.

Provider: A provider is a person or an organization who delivers health care services.

Example: A doctor, hospital, laboratory and dentist are examples of a provider.

Example: When you fill a prescription, the pharmacy is a provider of health care services.

Provider Network: A provider network is all of the providers who have an agreement with the health plan to deliver medical or health care services to plan members. Once in the provider network, the providers are known as participating providers.

Example: Your health plan may contract with one or more providers to deliver health care services to enrollees in your health plan.

Retrospective Review: This occurs when your health plan reviews a covered service after the service has been provided, and the Health Plan has been billed. The Health Plan decides if the service was medically necessary as part of its decision to pay for the service.

Example: A laboratory test was ordered by your physician, and performed by an in-network laboratory, which billed for the service. However, your health plan reviewed this and decided that such a test was not medically necessary. You may or may not be responsible for payment of this procedure.

Rider: This is a separate part of your health care coverage that adds specific benefits to your general health plan coverage. There will be an additional cost for a rider paid. Riders are agreed to before you enroll in a health plan.

Example: Your health plan agrees to provide prescription coverage for an additional \$10.00 per month. This \$10.00 is added to your monthly premium if you choose to obtain this prescription rider.

Example: Your health plan agrees to provide routine dental coverage for an additional \$15.00 per month. Your employer has selected this rider on your behalf. This \$15.00 is added to your monthly premium and is paid for by your employer.

Risk Sharing: A participating provider has an agreement with your health plan to provide all covered services. The health plan and the participating provider agree on how much the provider will get paid for these services. If the cost of the services is more than what was agreed to, then the health plan and the participating provider agree to share in the extra cost. If the cost of the services is less than what was agreed to, then the health plan and the participating provider agree to share in the money saved.

Example: Your health plan pays your provider \$300 a year to take care of you. The cost of your health care is \$400 for the year. Your provider and health plan share the added costs of your health care.

Example: Your health plan pays your provider \$300 each year to take care of you. The cost of your health care is \$200 for the year. Your doctor and health plan share the money saved.

Second Opinion: When you go to a second provider for a recommendation on the first provider's diagnostic or treatment plan.

Example: Your doctor recommends surgery for your health problem. You go to a second doctor and ask whether you need the surgery the first doctor recommended.

Subscriber: A subscriber is the person with whom the health plan has an agreement. The health plan agrees to provide health care services to the subscriber and all other members of his/her family covered in the agreement.

Example: Your employer provides health care coverage for you, your spouse and your children. You are the subscriber because the policy is in your name.

Urgent Care: A serious but not life threatening medical or health problem which needs to be treated by a provider within 24 hours to prevent the problem from getting worse is known as urgent care.

Example: You are vomiting and have a high fever. You are treated by your provider that same day. This visit is an urgent care visit.

Utilization Review: A utilization review is conducted by your health plan. The plan reviews the covered services ordered by your provider to decide if the services are medically necessary.

Example: You are planning to go into the hospital and you let your health plan know. Your health plan reviews the request for the service and your medical condition, and determines if your planned hospital stay is medically necessary.

Example: You are in the hospital and your health plan reviews your care and medical condition while you are still in the hospital to determine if more days in the hospital are medically necessary.

Example: You were in the hospital for two days. Your health plan reviews your care, your medical condition, and the services you received during those two days to decide if your two-day hospital stay was medically necessary.